The Massachusetts Department of Public Health
HIV/AIDS Bureau

Consumer Advisory Board Handbook

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Massachusetts Department of Public Health
HIV/AIDS Bureau
250 Washington Street, 3rd Floor
Boston, MA 02108
(617) 624-5300

Acknowledgments

In 2003, the Consumer Office of the Massachusetts Department of Public Health HIV/AIDS Bureau with the support and guidance of the Statewide Consumer Advisory Board (Statewide CAB) developed and released guidelines for CABs in the Commonwealth, including agency CABs and consortia CABs. Since that time the structure of the Statewide CAB has been modified and the Department has initiated a system of Service Coordination Collaboratives (SCCs). This handbook reflects those changes and includes additional guidance for agency CABs. The HIV/AIDS Bureau would like to thank the members of the Statewide Consumer Advisory Board, and the community members and providers who contributed their time, energy, and expertise to the production of this handbook.

In memoriam

Phatiwe S. Cohen
Special Projects Coordinator
HIV/AIDS Bureau

Table of Contents

APPENDICES

ADDENDUMS

1) Purpose

This handbook was developed through a collaborative effort between the Consumer Office of the Massachusetts Department of Public Health (MDPH) HIV/AIDS Bureau (HAB) and the Statewide Consumer Advisory Board (SWCAB) in order to integrate and strengthen the Consumer Advisory Board (CAB) system in Massachusetts, and to support the involvement of people living with HIV in the planning, delivery and assessment of HIV-related services in the Commonwealth.

2) The Consumer Office

The Consumer Office of the MDPH HAB works to ensure that people living with HIV/AIDS have input into the creation, development, and implementation of all HAB services and policies. This is achieved through the staff of the Consumer Office, who are people living with HIV, and through the SWCAB, which is coordinated by the Office. In addition to working with the SWCAB, the Consumer Office staff work with all of the service units of the HAB (Client Services, Health Services, and Prevention & Education). The Consumer Office is the primary contact for all issues related to the SWCAB, agency CABs, and consumer involvement in Service Coordination Collaboratives (see section six [Consumer Involvement] or Addendum IV [SCC Guidelines] for information about Service Coordination Collaboratives). This includes questions about operations, structure, membership, etc. The Consumer Office is also available to provide technical assistance on agency CAB development including leadership skills, member recruitment and retention, by-laws development, code of conduct, confidentiality, community activities, and other issues related to operations. This assistance may take the form of consultations over the phone, written recommendations (emails or letters), or Consumer Office staff attendance at meetings or with agency staff. The Consumer Office is available to support consumers in accessing services and to work with consumers and agencies on grievances that have not been resolved at the agency level, and provide other support as needed to people living with HIV. See section 14 for additional information about grievances. The Consumer Office is currently staffed by Sophie Lewis, Consumer Office Director, and Paul B. Goulet, Consumer Office Coordinator. Contact information is as follows:

Sophie Lewis
Massachusetts Department of Public Health
HIV/AIDS Bureau
250 Washington St., Third Floor
Boston, MA 02108
617-624-5366
(800) 443-2437
sophie.lewis@state.ma.us

Or
Paul B. Goulet
Massachusetts Department of Public Health
HIV/AIDS Bureau
250 Washington St., Third Floor
Boston, MA 02108
617-624-5389
(800) 443-2437
paul.b.goulet@state.ma.us

3) Introduction

In June 1983, the Second National AIDS Forum was convened in Denver, Colorado. At the meeting, an advisory committee of people with AIDS drafted the "Denver Principles" affirming the right of people with AIDS (PWA) to actively participate in their own health care and to be involved at every level of decision making. Five of the 17 principles played a particularly important role in shaping AIDS policies and programs in the United States. They stated that PWA:

- Have a right to quality medical treatment and quality social service provision without discrimination of any form, including sexual orientation, gender, diagnosis, economic status and race;

- Have a right to full explanations of all medical procedures and risks, to choose or refuse their treatment modalities, to refuse to participate in research without jeopardizing their treatment and to make informed decisions about their lives;

- Have a right to confidentiality of medical records, to human respect, and to choose who their significant others are;

- Should be involved at every level of decision making and specifically serve on the boards of directors of provider organizations; and

- Should be included in all AIDS forums, with equal credibility as other participants, to share their own experiences and knowledge.

The formation of local PWA coalitions and the National Association of People with AIDS helped keep consumer involvement at the forefront of America's response to the AIDS epidemic. HIV service demonstration projects funded by private foundations in the 1980's strongly encouraged consumer participation in assessing service needs and planning for delivery of coordinated health and support services. In addition, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act mandated PWA representation on HIV/AIDS Consortia through what came to be known as the Consumer Advisory Board (CAB) system.[1]

4) The Massachusetts Consumer Advisory Board System

The Massachusetts Consumer Advisory Board (CAB) system was created in 1991 in the belief that the opinions, experiences and perspectives of individuals living with or affected by HIV/AIDS (hereafter referred to as consumers) are essential to the development of strategies to effectively address issues raised by the HIV/AIDS epidemic. All agencies funded by the MDPH HAB for Client or Health services are required to create, support, and maintain a CAB. If an agency is unable to support a CAB, they must identify another mechanism for consumer input into services, which must be approved by their HAB Contract Manager. The CAB System refers to the Statewide Consumer Advisory Board and agency CABs.

[1] HRSA Care Action, Positive Partners: Consumer Involvement in HIV Care

It is the mission of the CAB system to provide a mechanism for consumers to have meaningful input into the development of policies and programs that address their needs. CABs seek to support the creation of comprehensive, community-based HIV/AIDS prevention, care and support services that are accessible, inclusive, responsive and of high quality.

As service users, consumers are well positioned to assess the quality, appropriateness, and effectiveness of funded services. In the pursuit of this mission, the CAB system has set the following goals:

- To provide consumer input to the development and implementation of Massachusetts Department of Public Health (MDPH) HIV/AIDS programs and policies and community-based providers.

- To ensure significant consumer input to community programs providing HIV/AIDS- related services through the development of local CABs or the inclusion of consumers on agency Boards of Directors.

- To act as liaison between consumers, the MDPH HIV/AIDS Bureau (the Bureau) and service providers.

- To educate and bring together consumers through a variety of activities that support health promotion and encourage consumer involvement.

The SWCAB achieves these goals through their direct relationship with the HAB; agency CABs achieve these goals through representation on the SWCAB, or through contact and work with the Consumer Office.

5) Benefits to Consumers and Providers

The relationship between consumers and service providers creates an environment that fosters the following benefits to both consumers and the agencies or other community groups they advise:

- The development of consumer self-determination and independence through increased knowledge, the fellowship and support of other consumers, and an environment of decreased stigma and isolation.

- The development of leadership skills and a sense of empowerment among consumers that aids them in their roles as advisors to agency CABs and Service Coordination Collaboratives (SCCs).

- The maintenance of a partnership in wellness with consumers aiding providers in improving service quality, informing type of service, informing program evaluation, and focusing provider programmatic policies on consumer needs and concerns.

- The creation of networking opportunities that increase consumer knowledge and provider sensitivity to consumer needs.

6) Consumer Involvement in CABs and Service Coordination Collaboratives

The CAB system is comprised of the SWCAB and agency CABs. Service Coordination Collaboratives (SCCs) are a group of care and support service providers and consumers whose charge is to improve the system of available services for people living with HIV/AIDS in a designated area of the state of Massachusetts. Although SCCs are not CABs, they represent a vital mechanism for people living with HIV to have input into the service system and are therefore included in this section.

(a) Statewide Consumer Advisory Board

The SWCAB is composed of up to 30 consumers. Member recruitment is done through an annual application process and selected candidates must represent the profile of the epidemic in Massachusetts in terms of race/ethnicity, gender, sexual orientation, age, and mode of transmission as well as regional representation. Candidates must also be or have been involved in agency CABs or other HIV related community-based groups. Members are appointed for a period of three years but there is no limit to how many terms they may serve.

The mission of the SWCAB is to provide advice to the staff and senior management of the MDPH HIV/AIDS Bureau and to work collaboratively on a range of strategies, policies and programmatic issues affecting the lives of consumers and individuals at risk. It works with the Bureau to achieve the Bureau's three goals to:

- Increase the number of persons at risk who know their status
- Decrease the number of new HIV infections
- Improve the health and quality of life for those who are living with and at high risk of HIV

As part of their advisory role, the SWCAB performs a number of activities each year that are articulated in the SWCAB Annual Plan. The Annual Plan is a document created by the SWCAB in collaboration with the Consumer Office and the HIV/AIDS Bureau Director that articulates the work of the SWCAB for the upcoming year. Additionally, upon request, individual SWCAB members make periodic visits to agency CABs to provide support, exchange information, and maintain connections between the SWCAB and the rest of the CAB system.

The SWCAB structures its work through three project based teams as well as through the work of the full SWCAB. The three teams are Influence, Visibility, and Communication. Each team has two team leaders who are elected at the start of each project, and serve for the duration of that project. The six team leaders make up the Management Team, and are responsible for setting the agenda for the full SWCAB meeting and facilitating that meeting on a rotating basis. This structure creates a more equal environment where no single person is identified as the leader, and new leaders are cultivated with each project.

(b) Agency CABs

Agency CABs are composed of current or past HIV+ clients who advise the agency on policy and programmatic issues. All HIV/AIDS Bureau Client Services and Health Services funded agencies are required to support and maintain a CAB. If an agency is unable to fulfill this requirement, they must identify alternative mechanisms for soliciting consumer input, which must be approved by their Contract Manager. In addition to CAB requirements, all AIDS Service Organizations are required to have 25% representation from consumers on their board of directors.

As advisory bodies to agencies, agency CABs require active engagement and support of agency staff. Agencies bear the responsibility for their CAB's actions and for the needs and safety of its members. The agency CAB is responsible to the agency itself as it represents an aspect of the agency's work and reflects the agency's goals and mission. Through this collaboration agency CABs represent an essential link to the agency and to the services the agency provides.

Agency CAB Requirements

Relationship Between Agencies and CABs

CABs and agencies work in partnership to achieve their goals. While CABs should be involved in all aspects of CAB operations, agencies have ultimate responsibility for the functioning of the CAB, and final decision making authority. Agencies have the responsibility to bring issues and/or projects to the CAB. Agencies are responsible for providing support to the CAB, including securing a location, providing staffing, and providing food and other incentives. CABs should have significant input into all documents of operations, such as by-laws and annual plans, with agencies having the final approval. The same applies to CAB membership and agenda setting. CABs are not independent bodies, they are partners with the agency, and both the CAB and the agency they advise must work together to develop the partnership.

CAB Membership

CABs should be composed of current or past HIV+ agency clients. On rare occasions, CABs may decide on a case-by-case basis to allow non-HIV+ clients to participate on their CAB. If CABs allow non HIV+ clients to participate, their role should be clearly articulated, they should not hold leadership positions, and their voting rights should be discussed by the CAB prior to their seating. Non-HIV+ CAB members should never represent a majority of the CAB. CABs and agencies should work together to decide on member recruitment and the process for selecting and seating members, with final decision making authority resting with the agency.

Meetings and Minutes

Every agency CAB is required to meet at least four times per year. At each meeting, minutes must be recorded and then forwarded to the Consumer Office. Some CABs assign a CAB member to take minutes, however it is ultimately the responsibility of the agency to ensure that minutes are taken and distributed.

By-laws and other Articles of Organization

By-laws, guidelines, and other documents that describe how a CAB functions are not a strict requirement, but are strongly encouraged. By-laws describe the purpose of the CAB, how it operates, who can participate, and what is expected of members and leaders. While some CABs create their own articles of organization, it is the responsibility of agencies to ensure that these articles exist and are up- to-date, to provide any support to the CAB for the creation of appropriate documents, and to ensure that the documents are in line with agency policies.

All by-laws should include the following sections:

- The CAB's mission
- The CAB's definition of a consumer (consumer, parent/guardian, partner, caretaker, etc.)
- When and how leaders are elected (chair, vice-chair, secretary, treasurer, etc.)
- The roles and responsibilities of the leaders
- How someone becomes a member
- Rules about attendance and voting procedures, including quorum
- Code of conduct (see section 10)
- Stipend eligibility
- How grievances are handled

(See sample by-laws in appendix C)

Annual Plan

Although not a requirement, agency CABs are strongly encouraged to create a yearly annual plan that describes the CAB's proposed projects and anticipated budget for the year. The plan should be submitted to the Consumer Office at the HIV/AIDS Bureau. If there is a question about the appropriateness of the CAB's plan, the consumer office should be contacted. The consumer Office is also available to provide technical assistance to help CABs develop their plans.

Other Mechanisms for Consumer Input

Agencies that are unable to maintain a CAB must be able to document their recruitment efforts and the reasons for their lack of success. Those agencies must still be able to demonstrate mechanisms for consumer involvement in decisions related to agency programs (e.g., surveys, focus groups). The consumer Office is available to provide technical assistance.

(c) Service Coordination Collaboratives

SCCs or Service Coordination Collaboratives are a group of care and support service providers and consumers whose charge is to improve the system of available services for people living with HIV/AIDS in a designated area of the state of Massachusetts. Each SCC strives to meet four broad goals:

- Improve the referral network of existing resources
- Assess service system quality
- Identify and address service gaps
- Maximize access to services while minimizing inefficiencies

There are eleven (11) Service Coordination Collaborative (SCCs) areas throughout Massachusetts representing all regions in the State. MDPH has contracted with local agencies to convene and facilitate the SCCs. Please see Addendums V and VI for a list of SCC areas and the contact information for the local convening agency, and the agencies funded within each area.

Membership

Consumers are critical to the SCC process. For purposes of SCC membership, a consumer is any individual who identifies within the SCC as a person living with HIV/AIDS, or the parent or guardian of an individual under age 21 living with HIV/AIDS. SCCs do not have separate Consumer Advisory Boards, instead consumers are full, equal members of the SCC and have the same opportunities for input that are afforded to all members. Active consumer participation is the only way to ensure that the SCC's discussions are realistic and well informed. The HIV/AIDS Bureau requires that consumers account for at least 25% of the SCC membership. In addition to consumer members, the MDPH HIV/AIDS Bureau requires that all agencies receiving funding for client services (including residential services), enhanced medical management services, comprehensive home health services, and correctional health services be active members of their SCC. Being an active member of the SCC includes having appropriate staff attend and participate in SCC meetings.

SCC Requirements

The HIV/AIDS Bureau expects each SCC to deliver products that reflect the goal of the SCC. By the beginning of each fiscal year, the SCC must develop a work plan, covering the entire fiscal year that describes what the SCC will focus on and what the end products will be. The work plan will describe in detail exactly what the group plans to do and how the work of the group will lead to an end product that furthers the goals of the SCC. Please see Addendum IV for the complete SCC Guidelines.

7) Other CAB Activities

There are other activities that all CABs are encouraged to engage in, such as:

- Reaching out to HIV-positive individuals who may or may not know their HIV status but are not receiving medical care and social support;
- Supporting newly diagnosed individuals;
- Educating the larger community about issues and challenges raised by the epidemic through speaking engagements, HIV/AIDS literature, radio spots, community access cable channels, etc.;
- Volunteering at provider agencies to assist staff who may be operating with less capacity due to funding losses;
- Fundraising (see section 8);
- Participating in community events (see section 9); and
- Any other activity that advances the Bureau goals of 1) getting individuals to learn their HIV status, 2) reducing the number of new infections, and 3) improving the health and quality of life of people living with, and those at risk of, HIV.

8) Fundraising

Strict compliance with all applicable federal, state and local laws associated with fundraising is critical. That said, CABs are encouraged to conduct fundraising to help enhance services in their regions or to support consumer educational and networking events. In order to conduct fundraising activities, a non-profit agency with federal 501(c)3 (federal tax-exempt) status must sponsor them. The CAB should consult with local HIV/AIDS service providers or their local SCC to get support and guidance whenever engaging in this type of activity.

9) Participation in Community Events

CAB visibility contributes to the reduction of HIV-related stigma by putting a face to the epidemic and dispelling myths and misconceptions about HIV and those who are living with it. It is therefore important for the CAB to have visibility within the community that it represents. World AIDS Day, AIDS Walks, fundraising events, ethnic festivals, political events, etc., represent opportunities for the CAB to make its role and purpose known within the community. It also provides opportunities to recruit new members for the CAB or to encourage others to learn their HIV status and get into care.

There are CAB members who do not feel comfortable disclosing their HIV status to the community. While some consumers believe that public disclosure is essential, others may be more comfortable with limited disclosure in which they may be willing to make their status known within the CAB, SCC, or other forum with the understanding that their status will not be revealed to the general public. These individuals can still participate in public events if they wish to and identify as consumer advocates, community health advisors, or community representatives. Progressive disclosure may occur with these individuals as their experience of living with HIV/AIDS evolves over time. Each CAB must respect and support an individual's decision about how widely s/he wishes to disclose.

10) Code of Conduct

In order to promote and maintain civility and effectiveness in the CAB system, it is essential that not only the policies and procedures be fair and clear but that the members be held accountable to a fair and clear code of conduct. Each CAB should include a code of conduct in the CAB by-laws. The following are some suggestions of what to include in a code of conduct:

- CAB members will demonstrate respect for fellow members during CAB meetings
- CAB members will respect the opinions of others, even if they disagree, and engage in open and productive discussions
- The confidentiality of all CAB members will be protected
- CAB members will arrive on time for meetings and stay until the conclusion of meetings, except for reasons discussed with a CAB officer or staff person prior to the meeting
- CAB members will take on and complete their fair share of the CAB work, as necessary
- CAB members will conduct themselves in full accordance with local and statewide guidance relating to CAB membership and participation
- CAB members will attend meetings fully prepared to participate in CAB business
- CAB members will not attend meetings under the influence of drugs or alcohol. If the CAB member does, s/he may be asked to leave the meeting
- CAB members will focus on issues and not individuals, will not make derogatory remarks about another member or staff person, use rude language, or disrupt the course of the meeting

11) How to Recruit Consumers as CAB Members

CABs should try to recruit a diverse membership that is reflective of the local epidemic in terms of race/ethnicity, gender, sexual orientation, age and mode of transmission. This is usually accomplished through carefully planned outreach into many different communities with the help of a variety of individuals, providers, SCCs, and other community groups. For CAB recruitment, ultimate responsibility rests with the agency.

Effective recruitment of consumers to participate in CABs requires understanding and overcoming a number of barriers that prevent or discourage membership. Some of these barriers include:

- Lack of knowledge about how to become involved
- Lack of confidence in ability to serve as a CAB member
- Difficulty of travel
- Language barriers
- Lack of written criteria for membership
- Unclear member roles, responsibilities, and expectations
- Belief that consumers are not taken seriously
- Perception that participation will not make a difference in one's own personal circumstances
- Fear of disclosure of HIV status, sexual orientation, drug use, etc.
- Limited physical or mental capacity
- Unfamiliarity with and/or discomfort with formality and complexity of CAB meeting procedures.

Some of these barriers might be overcome by having a nomination process that:

- Is broadly announced and publicized
- States time commitments
- Coordinates formal recruitment through a committee of the agency or SCC. In other words, responsibility for consumer recruitment should not be placed primarily on current CAB members but rather shared by the entire body that the CABs or consumers are working with, with ultimate responsibility resting on the agency.
- Explains how training, orientation, and on-going support is provided
- Clearly communicates expectations, roles and responsibilities, public visibility, etc.
- Clearly describes available supports, such as stipends, transportation assistance, child care, etc.
- Assures confidentiality outside of the meetings
- Assures language interpretation and translation of written materials
- Describes how consumers benefit from being involved. In other words, "what's in it for me?"
- Is extensive and ongoing, involving contact throughout the community rather than through a few organizations.[2]

[2] HRSA Sourcebook for People Living with HIV/AIDS

12) How to Retain Consumer Involvement in the CAB

Sustaining and maintaining effective consumer involvement requires continuing attention. Many factors related to the community, the CAB, and the individual might cause a member to become inactive or resign from the CAB. Ongoing recruitment is required to replace members who become too ill to serve, return to work, change their family status, move, get burned out, or change their priorities for community involvement. These are some of the most often reported barriers to continued involvement[3]. Other barriers include:

- Lack of clearly defined roles and responsibilities;
- Lack of orientation and training or mentoring of members;
- Internal struggle or conflict between CAB members, or CAB and agency
- Time, length and frequency of meetings;
- Poor relationships and conflict within the CAB;
- Long delays before "results" are seen;
- Lack of support for members with special needs (e.g., visually or hearing impaired, limited English proficiency); and
- Large geographic areas requiring time-consuming long-distance travel.

Many of the approaches that aid in recruitment also contribute to effective and sustained involvement. Additionally, an ***orientation*** would enable new members to participate actively in the CAB. Without a complete understanding of the CAB's function and purpose, a member cannot fully and effectively participate in the process. Therefore, it is incumbent upon the existing members to orient new members. Each CAB should have a new member orientation plan that explains the CAB process and describes the member's role within the CAB. The orientation should include an orientation packet containing the following information:

- Meeting schedule
- Structure (e.g., meeting format, leaders, etc.)
- By-laws
- CAB System Handbook
- Minutes from the last two meetings
- Stipend and reimbursement policy
- Annual plan
- Agency services and structure, and where the CAB fits within the agency
- Any other relevant information

[3]HRSA Sourcebook for People Living with HIV/AIDS

13) Conflict of Interest

CAB members are expected to openly identify any potential areas of conflict of interest in fulfilling their responsibilities. Identification of conflict of interest should be made verbally during any meeting in which a conflict arises and in writing to the chairperson in advance if possible. Conflict of interest is defined as participation in any decision that might result in actual or perceived, direct or indirect financial benefit to the CAB member or a member of their family.[4]

14) Grievances

If a consumer has a problem with a particular service or provider at a particular agency, that individual must utilize that agency's grievance procedure. This section is specifically about grievances between the CAB and agency or within the CAB between members. A grievance is an expression of dissatisfaction with a decision that has been made by the agency or the CAB, with the way some activity has been carried out, or with the behavior of a particular CAB member. The best way to handle a grievance or potential grievance is to prevent it in the first place. Grievances may be prevented if the CAB engages in consistent, open, and fair practices that allow for a wide array of input. Whether or not a CAB works to prevent grievances, a CAB member may still feel that a particular decision or action was unfair. If this were the case, it would be preferable for the CAB to handle the situation informally by talking openly about it and trying to reach some kind of resolution. If this informal method does not work the CAB should consult their grievance procedure identified in their by-laws. If neither method is successful then agency staff assigned to work with the CAB and their immediate supervisors should be consulted for further assistance. The Consumer Office should only be consulted after all of these steps have been taken and the issue is still unresolved.

[4] Statewide Consumer Advisory Board By-laws

Appendices

Appendix A: Meeting Structure, How to Run and Participate in a Meeting

There are multiple options for CAB structures. Most CABs follow a simplified version of *Robert's Rules of Order* (also know as *parliamentary procedure*), which is a set of rules for conducting meetings that allows everyone to be heard and to make decisions without confusion. For CABs that use this structure, the following guidelines may be helpful.

1. Electing a Chairperson

Each CAB should have a chair. The chair of the group generally serves as the meeting leader. In the absence of a chair, the co-chair or vice chair will generally be the meeting leader.

The chair (of any CAB) is responsible for several things:

- **Facilitate the meeting**. Facilitation includes many different responsibilities, including all of the following:
- **Call the meeting to order**. The chair is the person who will decide when to begin the meeting.
- **Move through the agenda**. It is up to the chair to ensure that the meeting moves smoothly and does not get stuck for too long on any one topic.
- **Recognize people who want to speak**. The chair should decide who should speak when so that everyone does not speak at the same time.
- **Acknowledge motions**. Once a member has made a motion, the chair must acknowledge it and ask for a second. The chair must then be sure that the group follows established voting procedure when acting on the motion.
- **Keep track of time**. Most people don't have all day to sit at a meeting. It is the chair's job to ensure that the meeting runs at a fluid pace and does not run over time.
- **Close the meeting**. In some cases, the chair will request a motion to adjourn. In other cases, the chair will simply end the meeting if no one has anything else to say.[5]

[5] Leadership Training 2000, Meeting Mechanics

2. Preparing an Agenda

The CAB chair is responsible for preparing the meeting agenda with input from CAB members. A comprehensive meeting agenda will include the following core components:

- **Welcome**
  This is where the chair will call the meeting to order and welcome members and guests.

- **Introductions**
  This is always an important step, especially where group members and guests may change from meeting to meeting.

- **Review/Approval of minutes from last meeting**
  This is the group's opportunity to confirm or not confirm the report of what happened at the last meeting.

- **Reports** (e.g. SWCAB, agency, SCC, budget, etc)

- **Old Business**
  This item gives the group the opportunity to revisit any issues from previous meetings that have not yet been resolved.

- **New Business**
  This is where the group has the opportunity to bring up new items that have not yet been discussed.

- **Presentation (if any)**
  This is the time during which any members or invited guests would have the opportunity to give a presentation about a particular topic of interest to the group.

- **Announcements/Information Sharing**
  This is when group members may announce upcoming events, items of interest, the time and date of the next meeting, etc.

- **Adjourn**
  The chair may or may not ask for a motion to adjourn and then, after a vote if the group requires one, end the meeting.

3. Taking Minutes

The minutes serve as the official written record of a meeting. Here are some tips for ensuring that the happenings at your meeting are preserved on paper and that all group members are kept up to date:

- **Have a recorder**. Without someone to take notes, you can't have minutes. This person can be the group's secretary, coordinator, or any other person who volunteers to listen and record what's happening.

- **Record everything**. This does not mean that every word spoken at the meeting should show up in the minutes, but it does mean that every topic discussed should at least be mentioned and all decisions documented. Some topics will require longer explanations than others.

- **Include attendance**. It is helpful to note who was at the meeting, and who was not. This will also help the person responsible for maintaining attendance records. (See confidentiality section below).

- **Be brief**. Use as few words as possible to explain what happened. Members are more likely to read the minutes carefully if they're not too long.

- **Distribute**. In order for everyone to be kept up to date, everyone must receive the minutes. This includes all group members, not just those who were at the meeting. It is also important to distribute the minutes quickly so that there is time to make necessary changes.

- **Maintain confidentiality**. Some groups use only first names in their minutes, some use only initials, some use full names. It is up to each group to decide. Be sure that the person taking minutes knows what the group has decided. Also, be sure not to identify people as being HIV+ unless they explicitly request that they be identified as such.[6]

[6] Leadership Training 2000, Meeting Mechanics

4. Operating Procedure/Respecting the Process

Here are some helpful hints for becoming a more effective member of the CAB:

- **Arrive on time**. The meeting process is often disrupted when people walk in after the meeting has begun.

- **Stay for the entire meeting**. The meeting process is often disrupted when people get up and leave before the meeting has ended.

- **Listen**. An effective participant in community planning listens to what others have to say.

- **Wait to be recognized before speaking**. A meeting runs smoothly when people who want to speak wait until they are recognized by the chair instead of calling out.

- **Be informed about the issues**. If you want to be a voting member of a group, it is very important that you understand the issues that are being discussed.

- **Ask questions**. If you do not understand the issues that are being discussed, be sure to ask someone in the group to explain them to you.

- **Focus on issues, not on personalities**. It is unlikely that you will like every person at the meeting. It is important to keep your focus on the issues at hand, and not on your dislike for someone in the group.

- **Refrain from side conversations**. While the meeting is being conducted, it is disruptive for people to be having other conversations at the table.

- **Be familiar with the group's by-laws**. Understanding the group's operating structure will help you understand what's happening at meetings.

5. Consensus and Voting

Every attempt should be made to reach consensus on decisions. Consensus means that while each member may not think a particular decision is the best one, it is a decision each member understands and is willing to support in public. Where consensus is not possible, a vote will be taken and a simple majority of a quorum will suffice. Here are a few tips for making sure that voting goes smoothly at your CAB:

- **Be consistent**. Use the same voting procedures for every vote at every meeting.

- **Use ballot votes for sensitive issues**. This allows for input without potentially embarrassing self-disclosure.

- **Ensure a quorum**. The group's by-laws should set out how many people make a quorum (that is, how many people are enough in order to take a vote. Generally, it's 50% of the entire membership plus one).

If you want your group's votes to be fair, follow the steps below and you won't go wrong:

- **Someone makes a motion**. A voting member of the group must "move" that an issue be voted on.

- **Someone seconds the motion**. At least two people must agree that a vote should be taken.

- **Issue opened for discussion**. At this point, the chair should ask if any further discussion about the issue is necessary before a vote is taken.

- **A vote is taken**. The chair will ask who is in favor of the proposed motion, who is opposed to it, and who chooses to abstain from the vote. A person may abstain (that is, not take part in the vote) any time the person feels that voting is not appropriate.

- **The votes are recorded**. The secretary, or whoever is taking the meeting minutes, should record how many people voted for or against the motion, and how many people abstained.

- **Motion carries or doesn't carry**. If enough people vote in favor of the motion, it carries. If there are not enough votes to carry the motion, it fails.

Appendix B: Description of HIV/AIDS Bureau Goals and Programs

The Massachusetts Department of Public Health HIV/AIDS Bureau's programmatic goals are to:

- Increase the number of persons at risk who know their status
- Decrease the number of new HIV infections
- Improve the health and quality of life for those who living with, and at high risk for HIV

Our programs and our dedicated employees strive to promote full access to services for persons most at risk for HIV infection, and those living with HIV/AIDS. In order to accomplish this mission, the Bureau operates three programmatic units and two support units.

Programmatic Units

Client Services
The Client Services Unit oversees the provision of an array of support services for people living with HIV/AIDS and for their families. These services include, among others, case management, meals, transportation, childcare, alternative therapy, and residential services. The goals of these support services are both to assure access to appropriate HIV clinical care and to maximize the ability of people with HIV/AIDS to live with dignity and support in the least restrictive community setting.

Health Services
The Health Services Unit oversees programs that provide clinical services for persons living with HIV/AIDS: primary care provided through the Enhanced Medical Management Services (EMMS), Corrections, Counseling and Testing, including rapid testing, and Home Health. Health Services strives to enhance the access of high-risk populations to culturally, linguistically, and population competent HIV/STD counseling and testing, primary care, and supportive psychosocial services. Projects within this unit focus on development and evaluation of health care services that respond to the evolving diagnostic, clinical and psychosocial support needs and resources of persons living with HIV/AIDS.

Prevention & Education
The purpose of the Prevention and Education Unit is to develop supportive relationships with a network of community based providers in order to deliver targeted, effective, sustained, theory-based AIDS prevention interventions to individuals and communities at high risk of HIV infection. The overall goal is to reduce the levels of HIV risk behavior among these individuals, to reduce the incidence of new HIV infections, and to address the complex factors that contribute to risk in communities.

Support Units

Policy & Planning

The Policy and Planning Unit is responsible for development of programmatic policy, planning, research and evaluation, training, and public information. Acting in a support capacity, this unit works closely with the three program units, frequently facilitating inter-unit collaboration. Unit staffs also manage the HIV Drug Assistance Program and other special projects. A majority of the work involves oversight of contracts for need assessments, evaluation, and training. The Consumer Office is housed in this unit.

Administration & Finance

The Administration and Finance Unit provides the central support for all budgetary, contract and procurement, information technology services (ITS), and personnel and operations functions in the HIV/AIDS Bureau. Staff act as point persons and liaisons to MDPH central systems including the Office of Budget, Accounting, Purchase of Service, central ITS, and Personnel and Human Resources. Staffs in the program units use this unit as direct contact staff for all of these major central functions.

Appendix C: Sample By-laws

Consumer Advisory Board
Sample By-laws
Mission, Goals, Roles and Procedures

MISSION

The mission of the CAB is to _____and to work collaboratively with (agency name) on a range of strategies, policies and programmatic issues affecting the lives of people living with HIV/AIDS and those at risk.

VISION AND VALUES

The vision and values of HIV/AIDS consumers in Massachusetts created the consumer advisory board (CAB) system, and has long held the value of maintaining consumer involvement in service creation, delivery, and assessment. The CAB system was established in the belief that the opinions, experiences, and expertise of individuals directly affected by HIV are essential for developing effective strategies to address issues presented by the HIV epidemic.

The mission, goals and procedures of the CAB are designed to provide clarity regarding the roles and functions of the CAB and to support the collaboration of all parties.

GOALS

Although the objectives of the CAB may change from time to time, there are three fundamental goals that support its mission:

Goal 1

- Provide consumer input to the (agency name) on the development, implementation and assessment of statewide HIV/AIDS policies.

Goal 2

- Promote significant input to HIV/AIDS service providers through the support and education of consumer advisory boards and promote the inclusion of people living with HIV/AIDS on agency CABs, SCCS, and other community based groups.

Goal 3

- Act as a liaison between consumers and the agencies, SCCs, or other community based groups, in the identification and resolution of problems.

MEMBERSHIP

The CAB membership is drawn from consumers in the _____ area. In addition, the CAB seeks to have as diverse a membership as possible so that the perspectives of people of all ages, races, ethnic groups, sexual orientation, etc., are represented.

Composition

1. The CAB will have at least _____ members.

How members are selected

1. Any individual infected or affected (define affected) may become a member.

2. Recruitment events will occur as needed and the CAB will circulate a description of the selection process, the roles and responsibilities of CAB members, why it's important to be involved, how one benefits from being involved, etc.

3. CAB members are elected for _____ years.

4. Incumbent CAB members may reapply at the end of each term using the standard application process followed by other candidates. All candidates will be chosen according to the same criteria, e.g., regional diversity, racial/ethnic diversity, gender, sexual orientation, CAB system involvement, and completeness of application.

Responsibilities of Members

1. Members are responsible for opening ongoing dialogues with other consumers in their areas.

2. Members are encouraged to present the activities of the CAB to the agency, SCC, or other community based group.

3. Members are responsible for maintaining appropriate levels of confidentiality, and for declaring any potential conflict of interest regarding their role in CAB deliberations.

4. Members are responsible for attending monthly/bi-monthly/quarterly CAB meetings.

5. Members are responsible for notifying the Chair or his/her designee when s/he is unable to attend a particular meeting.

LEADERSHIP ROLES

1. The leadership of the CAB will be chosen by its full membership.

2. There will be a Chair, a Vice-Chair, a Secretary, a Treasurer, etc. elected by the membership annually.

Responsibilities of the Chair
The Chair will be responsible for:

- collaboratively planning the agenda of CAB meetings with the appropriate agency, SCC, or other community based group.
- serving as the primary link between the CAB and the agency, SCC, or other community based group.
- chairing the meetings of the full membership of the CAB.
- other duties that s/he agrees to assume at the request of or with the permission of the membership.

Responsibilities of the Vice-Chair
The Chair will make every attempt to include the Vice-Chair in any and all decisions and actions s/he takes as Chair. In addition, the Vice-Chair will assume the duties of the Chair if s/he is unable to carry them out.

Responsibilities of the Secretary
The Secretary will take notes at every meeting and distribute them to the members as quickly as possible.

Responsibilities of the Treasurer
The Treasurer will keep track of the CAB budget (if any) and present periodic updates to the CAB.

MAKING DECISIONS

Consensus
Because the CAB has a commitment to collaborative process, every attempt will be made to reach consensus on decisions. Consensus means that while each member may not think a particular decision is the best one, it is a decision each member understands and is willing to support in public. Where consensus is not possible, a vote will be taken and a simple majority of a quorum will suffice.

Quorum and Voting
A quorum for voting is fifty percent (50%) plus one of the full CAB voting membership.

Proxy representation or voting means that a substitute could represent and/or vote in place of a member. Proxy voting or representation is not allowed.

CODE OF CONDUCT

1. CAB members will demonstrate respect for fellow consumers during meetings;
2. The confidentiality of all consumers will be protected;
3. CAB members will arrive on time for meetings and stay until the conclusion of meetings except for reasons discussed with a CAB officer or staff member;
4. CAB members will take on and complete their fair share of the CAB work, as necessary;
5. CAB members will conduct themselves in full accordance with local and statewide guidance relating to CAB membership and participation;
6. CAB members will attend meetings fully prepared to participate in CAB business; and
7. Other.

CONFLICT OF INTEREST

CAB members are expected to openly identify any potential areas of conflict of interest in fulfilling their responsibilities. Identification of conflict of interest should be made verbally during any meeting in which a conflict arises and in writing to the Chair in advance if possible. Conflict of interest is defined as participation in any decision that might result in actual or perceived, direct or indirect financial benefit to the SWCAB member or a member of their family.

CHANGING THE BY-LAWS

A proposal for amendment to the by-laws shall be submitted in writing with a rationale to the Chair and Vice-Chair for their review and recommendation to the whole group.
A bylaw amendment must be passed by a two-thirds majority affirmative vote of the CAB.

Glossary

501(c)3	A designation for a non-profit agency as exempt from state and federal taxes. Many federal funds are designated for the use of non-profits only.
.	
ACTG	AIDS Clinical Trials Group – the federal AIDS drug testing group.
ACTG 076	A study to determine if AZT was safe for use by pregnant women and newborns to reduce the rate of transmission of HIV from mother to baby. The study showed that, for the women given AZT, transmission of HIV from mother to infant was reduced from about 25% to about 8%.
Acupuncture	A branch of traditional Chinese Medicine in which thin, solid needles are applied to set body points (called meridians) to normalize and redirect energy flow to create a healing impact.
ADAP	AIDS Drug Assistance Program: State based programs funded in part by Title II of the Ryan White CARE Act that provides therapeutics to treat HIV disease (also referred to as HDAP, or HIV Drug Assistance Program).
Adherence	Sticking to your medication schedules.
Adult Day/ Respite Care	*See Day and Respite Care*
Advocacy	The act of arguing in favor of something, such as a cause, idea, or policy.
AFDC	Aid to Families with Dependent Children
AIDS	Acquired Immune Deficiency Syndrome
AHC	AIDS Housing Corporation
Alternative Therapies	Also known as complementary therapies – therapies not traditionally associated with Western medicine. Includes such therapies as massage, acupuncture, Reiki, and chiropractic services.
Antiretroviral	A substance that stops or suppresses the activity of a retrovirus such as HIV. AZT, ddC, ddI, d4T, 3TC, saquinavir, ritonovir and indinavir nevirapine are examples of antiretroviral drugs.
ASO	AIDS Service Organization: An agency that provides services for people living with HIV/AIDS as its primary mission.

Asymptomatic	In an HIV-positive individual, there are no symptoms of HIV infection with the exception of acute retroviral syndrome and persistent generalized lymphadenopathy.
BPHC	(Boston Public Health Commission) It is responsible for administering city, Title I, and city HOPWA funds.
BSAS	Bureau of Substance Abuse Services of the Mass. Dept. of Public Health
CAB	Consumer Advisory Board
CARE Act	*See Ryan White CARE Act*
Case Management	Client-centered service that links clients with health care and psychosocial services in a manner that assures timely, coordinated access to medically appropriate levels of care and support services, and continuity of care. Key activities include assessment of the client's needs and personal support systems; development of a comprehensive, individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; and periodic re-evaluation and adaptation of the plan as necessary during the life of the client.
CBDPP	Community Based Dental Partnership Program
CBO	Community based organization
CD4	T-helper lymphocytes, also referred to as white blood cells, are an immune response to infection in the body. These are the host cells for HIV replication.
CDC	(Centers for Disease Control and Prevention) Federal agency with the mission to promote health and quality of life by preventing and controlling disease. This is the primary funder for the Department of Public Health prevention programs.
Confidentiality	The protections of one's personal and medical information. Massachusetts General Law Section 70F (M.G.L. 70F) gives legal protection of HIV-related information to people living with HIV.
Consumer	A person living with HIV/AIDS, or the parent or guardian of a person under the age of 21 living with HIV/AIDS.
Contract Manager	The HIV/AIDS Bureau staff person responsible for overseeing contracts between the HIV/AIDS Bureau and an agency.

Demographic Data	Information about individuals who use HIV-related support services. This information includes where the person lives or receives services, the person's race gender, and age, as well as how the person contracted HIV. Demographic data does not include names.
Disclosure	To make known one's HIV positive status to others.
DMA	Division of Medical Assistance. This agency administers MassHealth, also known as Medicaid.
DMH	Department of Mental Health
DPH	Department of Public Health (also referred to as MDPH, or Massachusetts Department of Public Health). It is responsible for administering state, Title II, and state HOPWA funds.
EAEDC	This is the Massachusetts general relief/financial assistance program providing Emergency Aid to Elderly, Disabled and Children.
EMA	Eligible Metropolitan Area
EMMS	Enhanced Medical Management Service
Epidemiological Data	Information about the trends of the HIV epidemic, including the number of people who have ever been diagnosed with HIV/AIDS and the number of people currently living with HIV/AIDS. Epidemiological data does not include names.
HAB	HIV/AIDS Bureau of the Massachusetts Department of Public Health
Harm Reduction	This public health approach engages individuals at their particular level of motivation for behavior change and assists individuals in considering a range of options that reduce immediate harm, but which may or may not have HIV, STD, Hepatitis or substance abuse reduction benefits.
HDAP	Massachusetts HIV Drug Assistance Program
HIV	Human Immunodeficiency Virus

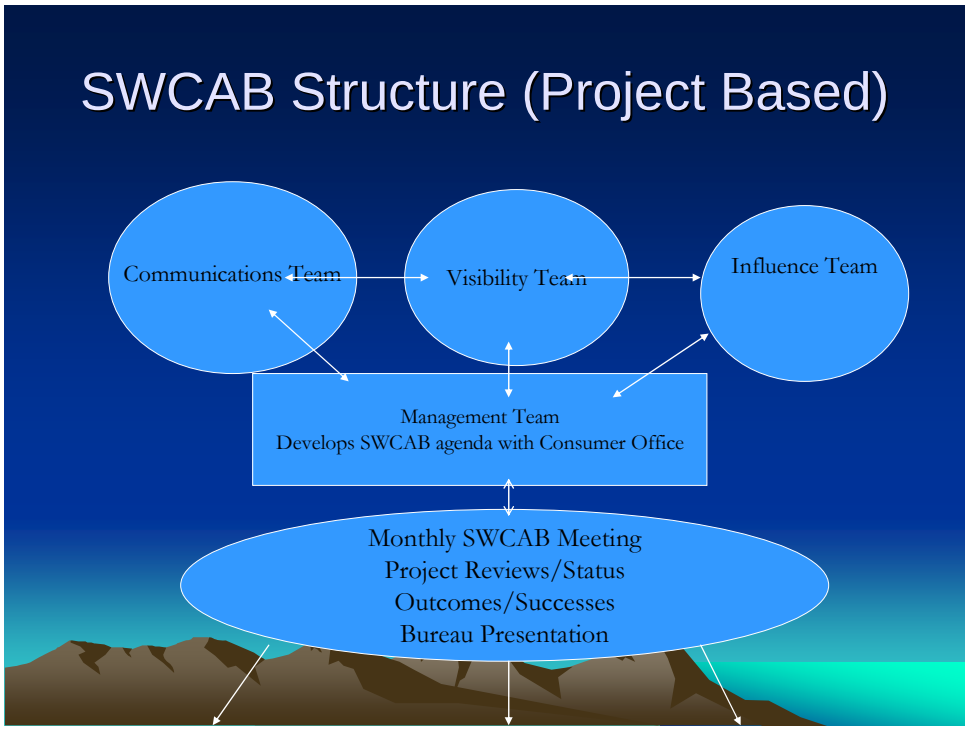
Home Health Care	Therapeutic, nursing, supportive, or other health services provided by a licensed/certified home health agency in a home/residential setting in accordance with a written, individualized plan of care established by a case management team that includes appropriate health care professional. Component services are typically considered to include Para-Professional Care (homemaker, home health aide, and personal/attendant care); Professional Care (routine and skilled nursing); Specialized Care (intravenous and aerosolized medication treatments, diagnostic testing, and other high tech services); and Durable Medical Equipment (prosthetics, devices, and equipment used by clients in a home/residential setting, e.g. wheelchairs, inhalation therapy equipment, or hospitals).
HOPWA	(Housing Opportunities for People with AIDS) A Housing and Urban Development program providing housing, housing assistance, and housing related services for people with HIV/AIDS.
HRSA	(Health Resources and Services Administration) The federal agency responsible for administering the Ryan White CARE Act.
IDU	Injection or Intravenous Drug User
Informed consent	Giving written permission to share one's personal information.
In care	Being in or receiving on-going medical care and/or treatment for HIV/AIDS**.**
MassCARE	A DPH program to ensure that children with HIV and their families receive family centered, community based, comprehensive and coordinated care.
MassHealth	Medicaid program in Massachusetts
MATTHCC	Massachusetts Association of Title II HIV Care Coordinators
MDPH	Massachusetts Department of Public Health. *See DPH*
Medicaid	Basic health care support for poor and/or disabled persons
MMP	Medical Monitoring Project
MPPG	Massachusetts Prevention Planning Group
MSM	Men who have sex with men
NAPWA	National Association of People with AIDS

NASTAD	National Alliance of State and Territorial AIDS Directors
Needle Exchange	A prevention program that exchanges used syringe needles for clean needles, provides referrals for substance abuse treatment, HIV Counseling and Testing, Hepatitis screening and vaccination, and provides harm reduction counseling.
Needs Assessment	An assessment of consumer need for HIV-related support services.
OI	Opportunistic Infection: an infection that has clinically significant consequences due to a person's weak immune system. There are 19 opportunistic infections classified by infectious agent and location of infection for a possible AIDS diagnosis.
Peer Support	Services that provide assistance to clients where the person(s) providing the service is HIV-positive or affected member of the client's self-identified community.
Perinatal Transmission	Transmission of HIV from mother to baby during pregnancy, labor and delivery, or through breastfeeding.
Planning Council	The Title I planning body. It is responsible for deciding the distribution of Title I dollars among service categories, prioritizing services, and establishing a long term, comprehensive HIV services plan for the Title I EMA.
Positive Prevention	Primary prevention for people living with HIV/AIDS.
Primary Medical Care	Provision of routine, non-emergency, non-inpatient, non-specialized medical care.
Provider	An agency or organization that provides support services for consumers.
Rehabilitation Care	Services provided by a licensed or authorized professional in accordance with an individualized plan of care that is intended to improve or maintain a client's quality of life and optimal capacity for self-care. This definition includes physical therapy, speech pathology, and low-vision training services.
Resistance	When a particular drug is no longer effective because of the ability of HIV to change over time.
RFR/RFP	(Request for Responses/Proposals) The competitive process used by the MDPH to select individuals or agencies to provide services.

Risk Assessment	A conscious on-going process to gauge one's level of risk when engaging in a particular activity.
Risk Reduction	A range of behavioral options to lower one's level of risk when engaging in a particular activity.
RWCA	Ryan White Comprehensive AIDS Resource Emergency Act of 1990. This is the federal legislation that authorizes the funding of medical and non-medical services for people living with HIV/AIDS.
SCC	Service Coordination Collaborative
SCSN	Statewide Coordinated Statement of Need
SSDI	Social Security Disability Insurance
SSI	Social Security Supplemental Income
Stigma	Something that detracts from the character or reputation of a person or group, i.e. reproach, shame, blame, disgrace
STD	Sexually transmitted disease
Substance Abuse Treatment	Provision of treatment and/or counseling to address substance abuse (including alcohol abuse)
SWCAB	Statewide Consumer Advisory Board
TA	Technical assistance
TIP	Transitional Intervention Program
Title I	These funds provide direct financial assistance to EMAs that have been the most severely affected by the HIV epidemic. The purpose of these funds is to deliver or enhance HIV-related (1) outpatient and ambulatory health and support services, including case management and comprehensive treatment services for individuals and families with HIV disease; and (2) inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, when medically appropriate, from inpatient facilities.

Title II	This section of the Ryan White CARE Act provides formula grants to States and Territories to improve the quality, availability, and organization of health care and support services for individuals and families with HIV infection. One major goal is to establish community-based, coordinated, continuums of care to which everyone with HIV will have access.
Title III	This section of the Ryan White CARE Act provides formula grants to existing community-based clinics and public health providers to develop and deliver early and ongoing comprehensive HIV services to persons with HIV/AIDS, on an outpatient basis.
Title IV	This section of the Ryan White CARE Act provides funds to support HIV comprehensive services for children, youth, women, and families using family-centered and youth-centered care models. Title IV also supports coordination between comprehensive care sites and clinical research programs to ensure voluntary access to clinical drug trials and other research.
Transmission	Passing HIV from an HIV positive person to an HIV negative person.
Utilization Data	Information about what HIV-related support services are being used, how often they are being used, and where they are being used. HIV Utilization data do not include names.
Viral Load	The amount of measurable virus in the blood. Tests to measure virus are PCR and bDNA.
Work Plan	A document that describes the planning activities a CAB, SCC, or other community based group will undertake.

Addendum I
SWCAB Structure/Communications


SWCAB Structure (Project Based)
Communications Team
Visibility Team
Influence Team
Management Team
Develops SWCAB agenda with Consumer Office
Monthly SWCAB Meeting
Project Reviews/Status
Outcomes/Successes
Bureau Presentation

Addendum II
SWCAB Reimbursement Policy

The Consumer Office

A Joint Program of JRI Health and the Massachusetts Department of Public Health AIDS Bureau
250 Washington Street, 3rd Floor, Boston, MA 02108
Phone: 617-624-5366 Fax: 617-624-5399 Toll free: 800-443-2437 Email: sophie.lewis@state.ma.us

Consumer Office Reimbursement Policy

The new Consumer office Reimbursement Policy begins May 16, 2006 and is not retroactive. If you have any questions regarding the Reimbursement Policy contact the Consumer Office Director. This policy applies to members of the Statewide CAB, and other consumers participating in Consumer Office activities.

Meeting Reimbursement Policy

Meeting Description		*Flat Rate*
Statewide CAB Meeting		$25
Team Meeting		$25

Please note that team members are eligible to receive **one stipend per month** for team meetings, for work done either at in-person meetings, email, or otherwise. If teams are meeting more than once per month, or if you are doing work for another team, prior approval must be received by the Consumer Office in order to receive a stipend.

Additional Consumer Office Related Meetings (*Requires approval from Consumer Office Director)*		
	up to one hour	$15
	up to 2 hours	$25
	up to 3 hours	$35
	each additional hour over 3 hours	$10*

*Not to exceed $75 for a meeting

Other meetings, such as trainings and proposal review, will be decided on a case by case basis.

CHILDCARE REIMBURSEMENT

For SWCAB members, childcare will be reimbursed in the amount of $25 per meeting for Meetings up five (5) hours. To receive reimbursement you must have the childcare provider complete the Consumer Office Childcare Reimbursement Form. A parent or guardian is not eligible to receive reimbursement and childcare is only available for children under the age of 14.

For meetings over 5 hours or overnight, contact the Consumer Office Director. Reimbursement of additional funds will be reviewed on a case by case basis.

TRAVEL REIMBURSEMENT

Use of public transportation or carpool is encourages when possible

- Mileage is paid at $.40/mile
- Mileage is calculated based on the state mileage amounts – please see attached
- Tolls will be reimbursed when the request is accompanied with a receipt
- Commuter rail fare will be reimbursed when the request is accompanied with a receipt
- Taxi fare will bee reimbursed request is accompanies with a receipt
- Members will also be reimbursed for the T and bus

PARKING REIMBURSEMENT

Parking will be reimbursed when accompanies by a receipt for the time of meeting only. For example, if a meeting starts after 5PM the member will be reimbursed at the after 5PM rate.

TELEPHONE CALL REIMBURSEMENT

The Consumer Office **will not** reimburse members for any phone calls.

CONFERENCE REIMBURSEMENT

(conference reimbursements are only applicable when conference attendance is pre-approved by the Consumer Office Director)

- Stipends are not given for conference participation
- Childcare expenses are reimbursed via the above policies
- There will be a per diem meal allowance at the following rate: $5 for breakfast, $10 for lunch, and $20 for dinner. **The meal allocation may not be used to buy alcoholic beverages. You are responsible for returning any unspent money.**
- Ground transportation to and from conferences will be given in advance for the expected cost. If the costs exceed the amount received, you will be reimbursed after the conference (a receipt must be submitted). You must have a receipt for all travel expenses, and you are responsible for returning any unspent money and money that you do not have receipts for.

WHEN TO EXPECT REIMBURSEMENT

Expect reimbursement by check within 30 days for the following:

- Childcare
- Out of pocket travel expenses (train, bus, taxi, tolls)
- Parking
- Food, if Consumer Office Director deems necessary

If cash is not available the day of the meeting, reimbursement checks will be mailed within 30 days.

ADDENDUM III
SCC Guidelines

Massachusetts Department of Public Health
HIV/AIDS Bureau
Guidelines for
Service Coordination Collaboratives
October 2005

Revised July 2006
Massachusetts Department of Public Health
HIV/AIDS Bureau
250 Washington Street, 3rd Floor
Boston, MA 02108
(617) 624-5300
Massachusetts Service Coordination Collaborative Guidelines 2
Rev. July 2006

Table of Contents

I. Introduction

At the beginning of federal funding for HIV/AIDS services, the relative needs of people living with HIV/AIDS were not well understood. At the same time, the HIV/AIDS service system was responding to the frequent influx of new funding and needed to expand rapidly throughout the Commonwealth. In order for this expansion to occur in a meaningful way, it was necessary to solicit local input about the service needs of people living with HIV/AIDS and to determine the optimal array of these services in various geographic areas of the state. To that end, the MDPH HIV/AIDS Bureau supported a system of local HIV care consortia that had primary responsibility for assessing service needs within their respective local areas, prioritizing services for funding, and making resource allocation recommendations within a lead agency/subcontractor contract structure. The range and interrelationship of the services for people living with HIV/AIDS in Massachusetts are now better understood, while the resource base for these services is reduced. This shift placed extraordinary pressure on the consortium system to determine how to allocate this shrinking funding base and to make recommendations about reducing or eliminating selected service categories. In response, the HIV/AIDS Bureau decided to directly fund case management and ancillary support services in its most recent procurement of client services, thereby eliminating the lead agency/subcontractor structure, as well as the system of local consortia that was no longer optimally suited to participate in necessary large-scale planning decisions.

The challenge for community involvement today centers on how to optimize the efficiency and effectiveness of the current service system at a regional level by examining the array of available services, identifying gaps, and determining to what degree referral linkages exist and are coordinated in order to effectively connect consumers to needed programs. The system of Service Coordination Collaboratives (SCC) now being implemented in Massachusetts is part of the natural evolution of community input from resource planning to service system coordination. The SCCs are intended to take local input to a new level and provide local stakeholders with a forum to present and address ideas for improving the HIV/AIDS service system as a whole.

II. Goals of a Service Coordination Collaborative

A. Overview

Each Service Coordination Collaborative (SCC) will strive to meet four broad goals: (1) improve the referral network of existing resources, (2) assess service system quality, (3) identify and address service gaps, and (4) maximize access to services while minimizing inefficiencies. Each goal addresses an issue that has emerged over time as a necessary stepping stone on the path to overall service system improvement. Although the goals are distinct, they are also interconnected in many ways. The process that the SCC develops to meet one goal may inform the process for meeting other goals. In addition, the actual results of those processes may provide a foundation for further processes. There is no prescribed method for meeting these goals, and each SCC will determine for itself how best to proceed. The only result that is expected from every SCC is that the group's work will ultimately improve the service system in some way for people living with HIV/AIDS.

B. Improve Referral Network

An effective and efficient referral network is a critical component of service coordination. Providers of all kinds of social support services must be able to refer clients to each other if the clients are to have access to a seamless continuum of care. Although most providers who serve people living with HIV/AIDS are able to provide and receive referrals without much difficulty, the referral network is still not perfect, and certainly not as broad as it needs to be. SCC members are responsible for the coordination of HIV/AIDS Bureau funded client services (including residential services), enhanced medical management services, comprehensive home health services, and correctional health services within the SCC's coordination area. Coordination of services among all of these providers will ultimately improve the referral network for consumers by making it easier for providers to connect with each other. This coordination effort must include an assessment of consumer service access, as well as development of strategies for making services more accessible when the assessment indicates such a need. An SCC is also responsible for reaching out to other service providers within the service coordination area and creating linkages that will help facilitate referral and collaboration, which will ultimately help to create a more comprehensive continuum of care for people living with HIV/AIDS. This includes reaching out to non HIV-specific providers that serve at-risk populations. Every SCC member is responsible for helping to ensure that these linkages are created.

C. Assess Service System Quality

The quality of the service system ultimately determines how well the needs of consumers are being met. A high quality system will ensure that all consumers have low-threshold access to all necessary and related primary care and support services. This is the goal of the HIV/AIDS Bureau's work. On an ongoing basis, each SCC is expected to assess the degree to which the service system within the SCC's coordination area is meeting the needs of consumers living in that area. This assessment should focus on how the system as a whole is functioning, and should not include assessment of specific provider agencies. This determination must take into account the kinds of services being provided, including those that are not HIV-specific (e.g., mental health and substance abuse services). A regional consumer needs assessment may assist with this, as well as a survey of services offered by existing providers in the region, along with the eligibility criteria attached to those services.

D. Identify and Address Service Gaps and Barriers

Although the existing HIV/AIDS service system addresses many challenges that people living with HIV/AIDS face, there remain gaps in available services. The SCC is responsible for designing methods to identify these gaps and developing strategies to address the identified gaps. For example, the SCC may analyze the results of the service system quality assessment to determine where gaps exist, or they may analyze aggregate service utilization data and compare the results of that analysis with the results of a regional needs assessment. By doing so, the SCC could identify what services consumers think they are missing, see if those results are consistent with the data, and then determine whether or not an actual gap exists. As part of the coordinator's reporting requirements, the coordinator will provide feedback on critical service gaps to the

HIV/AIDS Bureau so that the Bureau may consider whether or not redirection of resources is appropriate.

The SCC will also need to consider whether any identified gaps are a result of barriers and, if so, determine how best to overcome those barriers. Barriers may be related to available resources, agency capacity, staff diversity, comprehensiveness of the regional service mix, or any other category that has an effect on how consumers access services. The HIV/AIDS Bureau does not expect an SCC to take full responsibility for overcoming barriers to access. Instead, the Bureau and the SCCs will be partners in this endeavor.

E. Maximize Access and Minimize Inefficiencies

In a time of increasingly constricted resources, maximizing the use of every service dollar is critical. This means that every person in need of HIV/AIDS care and support services must be able to obtain necessary services quickly, easily, and cost-effectively. Increased and improved access to care and support services must be a priority for every SCC. Each SCC will have to determine the most efficient and cost-effective way to maximize access to services, including addressing underutilization of services, without unnecessarily duplicating the services that are available. For example, an SCC may propose adjustments to the service mix in the SCC's coordination area or may choose to address the schedule and location of service availability across agencies. The SCC might also determine that the most efficient means of improving access to services within the region is to develop mechanisms for sharing client information, with appropriate safeguards and releases in place, to expedite the referral process for consumers. Regardless of how the SCC opts to address this issue, the SCC must demonstrate that their efforts will ultimately result in a more efficient service system for their region.

III. Products of a Service Coordination Collaborative

The HIV/AIDS Bureau expects each SCC to deliver products that reflect the goals of the SCC. By the beginning of each fiscal year, the SCC must develop a work plan, covering the entire fiscal year, that describes what the SCC will focus on and what the end products will be. The products may be tangible (e.g., a regional referral tool) or intangible (e.g., better communication among members) and may be completed within the fiscal year or over a longer term. The work plan will describe in detail exactly what the group plans to do and how the work of the group will lead to an end product that furthers the goals of the SCC.

An essential component of engaging in goals related work is knowing the degree to which the goals of the group have been achieved. Therefore, in addition to creating actual products, the SCC must determine how it is going to evaluate the effectiveness of its products. The SCC's work plan will include a section that describes what steps the SCC plans to take in order to identify successes, as well as areas that require further attention.

There is no prescribed format for the work plan, but all work plans must include, at a minimum, the following:

- List of service system priorities related to each SCC goal that reflect the needs of the service coordination area, including a discussion of why these priorities have been identified;

• Description of the activities in which the SCC will engage in order to address its stated priorities;
• Timeline;
• Responsible parties;
• Description of end products, how the products will address the SCCs stated priorities, and how the products will be produced and delivered; and
• Proposed evaluation activities to measure the effectiveness of the SCC's work.

Although an SCC may prioritize and plan to address just about any issue, there are two exceptions. First, an SCC may not engage in advocacy efforts on funded time or in its name as an HIV/AIDS Bureau funded entity. This means that the SCC, as an entity, may not take any action related to the group's position on any proposed or pending state or federal legislation, or on any individual's candidacy for political office. It is illegal for a state-funded entity to engage in such activities. If the members of an SCC wish to engage in advocacy activities, they must do so on their own time and outside of the context of their SCC work. Second, an SCC may not engage in activities designed to raise money for the SCC itself or any other entity on funded time or in its name as an HIV/AIDS Bureau funded entity.

IV. Operating Procedures

A. Purpose

The HIV/AIDS Bureau requires every SCC to have a set of operating procedures, which describe the purpose of the group, how it operates, who may participate, the nature of that participation, and what is expected of members and leaders. These procedures serve as a place to turn for answers when questions arise within the group. This is not meant to be a long or complicated document, or necessarily as formal as by-laws. The operating procedures should maintain enough flexibility to allow the group to move forward and evolve over time while creating a structure that fosters collaboration and productivity.

B. Process

It is recommended that each SCC form an operating procedures committee to develop the SCC's operating procedures. The operating procedures committee will then bring its draft to the SCC membership for discussion, revision, and consensus adoption. At least once every two years, the procedures committee should review the operating procedures and make recommendations for amendments, if necessary, to the SCC. The HIV/AIDS Bureau has created sample operating procedures to assist with this process. The sample procedures may also be used as a template for the SCC's own procedures.

C. Elements

Operating procedures are often divided into several sections, each of which describes some aspect of the group's operations. An SCC can decide for itself what additional information it wants to include in its operating procedures, but all operating procedures should include, at a minimum, descriptions of the following:
• The SCC's purpose, mission, or other foundational statement;
• Definition of a member;

- The scope of the group's work;
- The roles and responsibilities of the SCC membership;
- The roles and responsibilities of the SCC coordinator/facilitator;
- How information is shared among SCC members and how members conduct themselves;
- A description of the SCC's committees, if applicable;
- How often the group meets and how minutes are shared;
- A protocol for addressing inclement weather on meeting days;
- A statement about confidentiality; and
- A mechanism for amending the operating procedures.

V. SCC Membership

A. Required Members

1. HIV/AIDS Bureau Funded Providers

The MDPH HIV/AIDS Bureau requires that all agencies receiving funding under contract with the Bureau for client services (including residential services), enhanced medical management, comprehensive home health, and correctional health be active members of their SCC. Being an active member of the SCC includes having appropriate staff attend and participate in SCC meetings.

2. Consumers

Consumers make up another group that is critical to the SCC process. For purposes of SCC membership, a consumer is any individual who identifies within the SCC as a person living with HIV/AIDS, or the parent or guardian of an individual under age 21 living with HIV/AIDS. Consumers will be full, equal members of the SCC and will have the same opportunities for input that are afforded to all members. Active consumer participation is the only way to ensure that the SCC's discussions are realistic and well informed.
The HIV/AIDS Bureau requires that consumers account for at least 25% of the SCC membership. If an SCC is unable to achieve the required 25% consumer representation, the SCC must make every effort to come as close as possible to the desired percentage, including submission of a written plan that explains the SCC's outreach and recruitment efforts. This plan must be submitted to both the SCC's contract manager and the HIV/AIDS Bureau Consumer Office.

A provider who is HIV-positive may choose to participate in the SCC as a provider, a consumer, or both. However, if the provider chooses to participate in the SCC solely as a consumer, and is employed by an agency that is required to participate in the SCC, that agency must send another staff person to represent the agency at the SCC meeting. (See section VI.E. for information about consumer stipends.)

B. Recommended Members and Other Participants

Because people living with HIV also receive services from providers whose services are not necessarily HIV-specific, these providers are encouraged to participate in their local SCC in any number of ways. Human service providers tend to serve populations that are at risk for HIV infection and, as a result, these providers often provide services to people who are HIV-positive. These providers therefore represent critical linkages for referral and collaboration within an area. Some providers may have a greater stake in the SCC's work and will want to be full members of the SCC. Others may participate in less formal ways and attend meetings periodically. Still others will serve primarily as sources of information and may be invited to speak at a particular meeting about a specific, designated topic. However these providers choose to participate, their input will be an important element of the SCC's work toward meeting its goals.

Examples of these other kinds of agencies or organizations include:

- Substance abuse treatment programs/detoxification centers
- Mental health providers
- HIV Prevention and education providers
- Counseling and testing sites
- Population-specific community-based organizations
- GLBT social and support organizations
- Jails
- Independent living centers
- Legal services
- Hospitals
- Community health centers/Ryan White Title III providers
- Ryan White Title IV/MassCARE providers
- STD clinics
- Representatives from state and local government
- Housing programs
- Faith-based organizations
- Visiting Nurse Associations
- Homeless shelters
- Emergency services providers
- Hospice
- Infectious disease specialists
- Workforce development specialists
- Literacy advocates

VI. Responsibilities of the SCC Contract Holder (Coordinator)

A. Coordination

1. Meetings

Each SCC must have a regular meeting schedule so that members and other participants know when to attend. The HIV/AIDS Bureau requires that each SCC meet at least four times per year. Beyond that, the SCC may meet as often as it chooses, depending on its needs. For

example, the SCC may choose to meet on the second Tuesday of every month, or the third Wednesday every other month, or whatever works best for the majority of members. The meeting schedule must be made available to all members.

The coordinator is responsible for:
- Recruiting consumers to be members;
- Informing members about upcoming meetings;
- Inviting outside providers to meetings, as appropriate;
- Securing an accessible meeting space;
- Providing food at meetings, as appropriate; and
- Taking attendance at each meeting and sending the attendance list to the SCC's contract manager within five days of the meeting.

In addition, the HIV/AIDS Bureau strongly recommends that coordinators develop evaluation forms to be completed by SCC members at the end of each SCC meeting. This will allow members to provide feedback on the meetings (location, facilitation, goals, etc.), which will in turn allow the meeting coordinators to make any necessary adjustments.

2. Committees

An SCC may choose to create committees for the purpose of addressing particular issues. If the SCC does so, the purpose, nature, and membership of the committee must be made known to the membership and described in the SCC's operating procedures.

3. Meeting Minutes

The minutes serve as the official written record of a meeting. The SCC must record minutes for every meeting so that they may be referred to in the future when information from a past meeting becomes important. The minutes must then be distributed to all SCC members and be approved (with corrections, if necessary) at the next SCC meeting. In addition, each SCC is required to submit a copy of the minutes from each meeting to the SCC's contract manager once the minutes have been approved by the SCC.

4. Confidentiality

SCC meetings are open and public meetings at which any number of individuals, whether members or visitors, may be present. Therefore, it is critical that meeting attendees utilize the utmost discretion when discussing information of a sensitive or personal nature. Such information includes, but is not limited to, information about a person's health or HIV status, relationship with any provider agency, employment situation, or involvement in a survey or focus group. The SCC should have a discussion about how best to manage confidentiality within the group, including how to note consumer attendance in the meeting minutes, and then codify the results of that discussion in the SCC's operating procedures.

To ensure the full integration of people living with HIV into SCC processes and discussions, consumers are strongly encouraged to identify as such within the group in order to ensure that all discussions held by the SCC are publicly and adequately informed by consumer input. Although some consumers may not feel comfortable disclosing their status in a public meeting, and cannot be compelled to do so, it is essential that meeting participants know when consumer input is being provided. To protect the confidentiality of these consumers

outside of the group, consumers are encouraged not to disclose their full name to anyone other than the meeting facilitator. Any questions that arise around confidentiality should be directed to the SCC's contract manager or to the HIV/AIDS Bureau Consumer Office.

B. Facilitation

The agency holding the SCC contract is being funded to plan, coordinate, and facilitate SCC meetings. The HIV/AIDS Bureau expects that this facilitation will be skilled, informed, and participatory. Group leaders will, of course, emerge from the membership, and this should be encouraged. However, it is the primary responsibility of the contract holder to run the meetings and ensure that the group's goals are met and the end products are delivered. It is also the responsibility of the facilitator to ensure that every meeting be a consensus process. Each decision reached by the SCC membership should be a consensus decision that reflects the general agreement of the group. See Appendix 1 for tips on consensus building.

C. Orientation

It is recommended that funded SCC coordinators, along with other SCC members, provide an orientation for all new SCC members. Although all SCC members will be new in the first year of the SCC system, it is expected that new members will continue to be identified over the life of the SCC. Without a complete understanding of the SCC's function and purpose, a member cannot fully and effectively participate in the process. Therefore, it is incumbent upon the veteran members to orient the new members. One way to help new members become acquainted with the SCC is to provide them with an orientation packet. Such a packet might include the following:

- The SCC's meeting schedule;
- The SCC's operating procedures;
- A list of SCC member agencies;
- The SCC's work plan;
- Meeting minutes from the past two meetings;
- The contract holder's contact information;
- A copy of the Guidelines for Service Coordination Collaboratives; and
- Any other information that might be relevant.

D. Reporting

At least two times per year, the coordinator will be responsible for submitting a report that describes the SCC's progress on its work plan activities. The HIV/AIDS Bureau will provide a format for this report. By the end of each fiscal year, the final products (or an update or description thereof) will be due. The priorities, activities, and products will necessarily vary according to the needs of the region represented by the SCC, but will all be related in some way to the four goals of the SCC system. In addition, the coordinator is responsible for maintaining ongoing communication with the Bureau and acting as a liaison between the Bureau and the SCC.

E. Appropriate Expenditures

Expenditures will be limited to those that directly support the SCC process. Appropriate expenditures related to coordination of the SCC and its meetings include the following:

- SCC staff and administrative support;
- Stipends for consumers attending SCC meetings;
- Reimbursement for transportation and child care for consumers attending SCC meetings;
- Language interpretation;
- Food and other refreshments for SCC meetings;
- Materials and supplies;
- Photocopying;
- Postage; and
- Advertising, announcements, and informational materials (e.g., brochures, resource guides).

Note that a provider staff person who also identifies as a consumer may receive a stipend only if the individual is attending the meeting solely as a consumer. As such, the individual must make it clear that s/he is not representing her/his agency at the meeting. The individual must not be on company time during the meeting and must not be receiving compensation from her/his agency for that time. If the agency at which the individual is employed is required to participate in the SCC, the agency must send another staff person to represent the agency at the meeting. It is permissible for an individual to attend a meeting as both a consumer and an agency representative, but in that case the individual may not receive a stipend.
If the SCC creates printed informational materials about the SCC and its work (e.g., brochures, resource guides), the coordinator must submit a final draft of the materials to the SCC's contract manager before the materials are printed and distributed. This will help ensure that the information is accurate and that the language is consistent with HIV/AIDS Bureau principles.

VII. Technical Assistance

Each SCC is a partnership between the HIV/AIDS Bureau and the community. Although the focus of the SCC system is on community organization and leadership, there will be times when the SCC will require the assistance of the HIV/AIDS Bureau. When the SCC, or the SCC coordinator, feels that technical assistance is required, the coordinator should contact the SCC's contract manager. The contract manager will then determine how best to assist the SCC.

Appendix 1: Consensus Building

What is consensus?
Consensus is a process for group decision making. It is a method by which an entire group of people can come to an agreement. The input and ideas of all participants are gathered and synthesized to arrive at a final decision acceptable to all. Through consensus, we are not only working to achieve better solutions, but also to promote the growth of community and trust.

Consensus vs. voting

Voting is a means by which we choose one alternative from several. Consensus, on the other hand, is a process of synthesizing many diverse elements together. Voting is a win or lose model, in which people are more often concerned with the numbers it takes to "win" than with the issue itself. Voting does not take into account individual feelings or needs. In essence, it is a quantitative, rather than qualitative, method of decision making.
With consensus people can and should work through differences and reach a mutually satisfactory position. It is possible for one person's insights or strongly held beliefs to sway the whole group. No ideas are lost, each member's input is valued as part of the solution.

What does consensus mean?

Consensus does not mean that everyone thinks that the decision made is necessarily the best one possible, or even that they are sure it will work. What it does mean is that in coming to that decision, no one felt that her/his position on the matter was misunderstood or that it wasn't given a proper hearing. Hopefully, everyone will think it is the best decision.
Consensus takes more time and member skill, but uses lots of resources before a decision is made, creates commitment to the decision and often facilitates creative decision. It gives everyone some experience with new processes of interaction and conflict resolution, which is basic but important skill-building. For consensus to be a positive experience, it is best if the group has (1) common values, (2) some skill in group process and conflict resolution, or a commitment to let these be facilitated, (3) commitment and responsibility to the group by its members, and (4) sufficient time for everyone to participate in the process.

Forming the consensus proposals

During discussion a proposal for resolution is put forward. It is amended and modified through more discussion, or withdrawn if it seems to be a dead end. During this discussion period it is important to articulate differences clearly. It is the responsibility of those who are having trouble with a proposal to put forth alternative suggestions.

The fundamental right of consensus is for all people to be able to express themselves in their own words and of their own will. The fundamental responsibility of consensus is to assure others of their right to speak and be heard. Coercion and trade-offs are replaced with creative alternatives, and compromise with synthesis.

When a proposal seems to be well understood by everyone, and there are no new changes asked for, the facilitator(s) can ask if there are any objections or reservations to it. If there are no objections, there can be a call for consensus. If there are still no objections, then after a moment of silence you have your decision. Once consensus does appear to have been reached, it really helps to have someone repeat the decision to the group so everyone is clear on what has been decided.

Difficulties in reaching consensus

If a decision has been reached, or is on the verge of being reached, that you cannot support, there are several ways to express your objections:

Non-support: I don't see the need for this, but I'll go along.

Reservations: I think this may be a mistake, but I can live with it.

Standing aside: I personally can't do this, but I won't stop others from doing it.

Blocking: I cannot support this or allow the group to support this.

Withdrawing from the group: Obviously, if many people express non-support or reservations or stand aside or leave the group, it may not be a viable decision even if no one directly blocks it. This is what is known as a "lukewarm" consensus.

If consensus is blocked and no new consensus can be reached, the group stays with whatever the previous decision was on the subject, or does nothing if that is applicable. Major philosophical or moral questions that will come up with each affinity group will have to be worked through as soon as the group forms.

Roles in a consensus meeting

There are several roles which, if filled, can help consensus decision making run smoothly. The facilitator(s) aids the group in defining decisions that need to be made, helps them through the stages of reaching an agreement, keeps the meeting moving, focuses discussion to the point at-hand, makes sure everyone has the opportunity to participate, and formulates and tests to see if consensus has been reached.

Facilitators help to direct the process of the meeting, not its content. They never make decisions for the group. If a facilitator feels too emotionally involved in an issue or discussion and cannot remain neutral in behavior, if not in attitude, then s/he should ask someone to take over the task of facilitation for that agenda item.

A recorder can take notes on the meeting, especially of decisions made and means of implementation and a time keeper keeps things going on schedule so that each agenda item can be covered in the time allotted for it (if discussion runs over the time for an item, the group may or may not decide to contract for more time to finish up).

Even though individuals take on these roles, all participants in a meeting should be aware of and involved in the issues, process, and feelings of the group, and should share their individual expertise in helping the group run smoothly and reach a decision. This is especially true when it comes to finding compromise agreements to seemingly contradictory positions.

Adapted from ACT UP, *Consensus Decision Making*, Retrieved October 18, 2005, from Http://www.actupny.org/documents/CDdocuments/Consensus.html.

ADDENDUM IV
SCC Geographic Areas and Contacts

SERVICE COORDINATION AREA	TOWNS/CITIES
Berkshire County	Adams, Alford, Becket, Cheshire, Clarksburg, Dalton, Egremont, Florida, Great Barrington, Hancock, Hinsdale, Lanesborough, Lee, Lenox, Monterey, Mount Washington, New Ashford, New Marlborough, North Adams, Otis, Peru, Pittsfield, Richmond, Sandisfield, Savoy, Sheffield, Stockbridge, Tyringham, Washington, West Stockbridge, Williamstown, Windsor
Hampshire County/Franklin County/North Quabbin Area	Amherst, Ashfield, Athol, Belchertown, Bernardston, Buckland, Charlemont, Chesterfield, Colrain, Conway, Cummington, Deerfield, Easthampton, Erving, Gill, Goshen, Granby, Greenfield, Hadley, Hatfield, Hawley, Heath, Huntington, Leverett, Leyden, Middlefield, Monroe, Montague, New Salem, Northampton, Northfield, Orange, Pelham, Petersham, Phillipston, Plainfield, Rowe, Royalston, Shelburne, Shutesbury, South Hadley, Southampton, Sunderland, Ware, Warwick, Wendell, Westhampton, Whately, Williamsburg, Worthington
Hampden County	Agawam, Blandford, Brimfield, Chester, Chicopee, East Longmeadow, Granville, Hampden, Holland, Holyoke, Longmeadow, Ludlow, Monson, Montgomery, Palmer, Russell, Southwick, Springfield, Tolland, Wales, West Springfield, Westfield, Wilbraham
South/Central Worcester	Auburn, Barre, Blackstone, Boylston, Brookfield, Charlton, Douglas, Dudley, East Brookfield, Grafton, Hardwick, Holden, Hopedale, Leicester, Mendon, Milford, Millbury, Millville, New Braintree, North Brookfield, Northborough, Northbridge, Oakham, Oxford, Paxton, Rutland, Shrewsbury, Southbridge, Spencer, Sturbridge, Sutton, Upton, Uxbridge, Warren, Webster, West Boylston, West Brookfield, Westborough, Worcester
North Worcester	Ashburnham, Ashby, Berlin, Bolton, Clinton, Fitchburg, Gardner, Harvard, Hubbardston, Lancaster, Leominster, Lunenburg, Princeton, Shirley, Sterling, Templeton, Townsend, Westminster, Winchendon
Northeast	Andover, Ayer, Billerica, Carlisle, Chelmsford, Dracut, Dunstable, Groton, Groveland, Haverhill, Lawrence, Lowell, Methuen, North Andover, Pepperell, Tewksbury, Tyngsborough, Westford

North Shore	Amesbury, Beverly, Boxford, Essex, Danvers, Georgetown, Gloucester, Hamilton, Ipswich, Lynn, Lynnfield, Manchester, Marblehead, Merrimac, Middleton, Nahant, Newbury, Newburyport, Peabody, Rockport, Rowley, Salem, Salisbury, Saugus, Swampscott, Topsfield, Wenham, West Newbury
South Shore	Abington, Attleboro, Avon, Berkley, Braintree, Bridgewater, Brockton, Canton, Carver, Cohasset, Dighton, Duxbury, East Bridgewater, Easton, Foxborough, Halifax, Hanover, Hanson, Hingham, Holbrook, Hull, Kingston, Lakeville, Mansfield, Marshfield, Middleborough, Milton, North Attleboro, Norton, Norwell, Pembroke, Plymouth, Plympton, Quincy, Randolph, Raynham, Rehobeth, Rockland, Scituate, Seekonk, Sharon, Stoughton, Taunton, Wareham, West Bridgewater, Weymouth, Whitman
Southeast	Acushnet, Dartmouth, Fairhaven, Fall River, Freetown, Marion, Mattapoisett, New Bedford, Rochester, Somerset, Swansea, Westport
Metrowest	Acton, Arlington, Ashland, Bedford, Bellingham, Belmont, Boxborough, Burlington, Concord, Dedham, Dover, Framingham, Franklin, Holliston, Hopkinton, Hudson, Lexington, Lincoln, Littleton, Marlborough, Maynard, Medfield, Medway, Millis, Natick, Needham, Norfolk, North Reading, Norwood, Plainville, Reading, Sherborn, Southborough, Stoneham, Stow, Sudbury, Walpole, Wayland, Wellesley, Weston, Westwood, Wilmington, Winchester, Woburn, Wrentham
Cape Cod/Islands	Barnstable, Bourne, Brewster, Chatham, Dennis, Eastham, Falmouth, Gosnold, Harwich, Mashpee, Nantucket, Orleans, Provincetown, Sandwich, Truro, Wellfleet, Yarmouth, (all towns on Martha's Vineyard)
Greater Boston	Boston, Brookline, Cambridge, Chelsea, Everett, Malden, Medford, Melrose, Newton, Revere, Somerville, Wakefield, Waltham, Watertown, Winthrop

Addendum V
Funded Agencies Within SCC Areas

Massachusetts Department of Public Health—HIV/AIDS Bureau

Funded Agencies for Client Services* (CS), Residential Support Services (RSS), Comprehensive Home Health (CHH), Enhanced Medical Management (EMM), and Correctional Health (J)**

FY2006

Service Coordination Area	Agency	Location	Contracts
Greater Boston/ Metrowest	**AIDS Action Committee**	Boston	CS, RSS
	Beacon Hill Multicultural Psychological Assn.	Boston	CS
	Boston Living Center	Boston	CS
	Boston Medical Center	Boston	EMM, CHH
	Cambridge Cares About AIDS	Cambridge	CS, RSS, J
	Cambridge Health Alliance	Cambridge	EMM
	Catholic Charities	Boston	RSS
	Center for Community Health Education and Research (CCHER)	Boston	CS
	Commonwealth Land Trust	Boston	RSS
	Community Servings	Boston	CS
	Dimock Community Health Center	Boston	EMM
	Fenway Community Health Center	Boston	EMM
	Health Awareness Services	Framingham	[BPHC only]
	JRI Health	Boston	CS, RSS, EMM
	Latino Health Institute—Proyecto Opciones	Chelsea/Revere	RSS
	Mass. General Hospital	Chelsea/Revere	EMM
	Metrowest Medical Center	Framingham	EMM
	Norfolk County Sheriff's Dept.	Dedham	J
	Pathways to Wellness	Boston	CS
	Pine Street Inn	Boston	RSS
	South Middlesex Opportunity Council (SMOC)—New Beginnings	Framingham	RSS
	Span	Boston	CS, J
	Suffolk County Sheriff's Dept.	Boston	J
	Upham's Corner Health Center	Boston	CHH
	Victory Programs	Boston	RSS
	Vinfen	Boston	RSS
	Whittier Street Neighborhood Health Center	Boston	RSS

Service Coordination Area	Agency	Location	Contracts
Northeast	Catholic Charities—Julie House	Lowell	RSS
	Greater Lawrence Family Health Ctr	Lawrence	EMM
	Home Health VNA	Lawrence	CHH
	Lowell Community Health Center	Lowell	CS, EMM
	Middlesex County Sheriff's Dept.	Billerica	J
North Shore	Essex County Sheriff's Dept.	Middleton	J
	Health and Education Services	Topsfield/Beverly	RSS, J
	Lynn Community Health Center	Lynn	EMM
	North Shore AIDS Health Project* **	Gloucester	CS
	Strongest Link	Danvers	CS
	VNA Care Network	Danvers	CHH
South Shore	**Brockton Area Multi-Services, Inc. (BAMSI)**	Brockton	CS, CHH
	Community Counseling of Bristol County	Taunton	CS
	Morton Hospital	Taunton	EMM, CHH
	Plymouth County Sheriff's Dept.	Plymouth	J
	Quincy Medical Center	Quincy	CS
	South Shore AIDS Project	Plymouth	J
Southeast	Bristol County Sheriff's Dept.	N. Dartmouth	J
	Center for Human Services	New Bedford	CS, RSS
	Coastline Elderly Services	New Bedford	CS
	Greater New Bedford Community Health Center	New Bedford	EMM
	St. Anne's Hospital—Hope House	Fall River	RSS
	Stanley Street Treatment and Resources (SSTAR)	Fall River	CS, EMM
	Steppingstone	Fall River	RSS
Cape Cod & Islands	**AIDS Support Group of Cape Cod**	Provincetown	CS, RSS
	Barnstable County Sheriff's Dept.	Bourne	J
	Cape Cod Hospital	Hyannis	EMM
	Outer Cape Health Services	Provincetown	EMM
	Town of Provincetown	Provincetown	CHH

Service Coordination Area	Agency	Location	Contracts
South/Central Worcester	**AIDS Project Worcester**	Worcester	CS
	Community Healthlink	Worcester	RSS
	Great Brook Valley Health Center	Worcester	EMM, J
	UMass Medical Center	Worcester	EMM, J[+]
	VNA Care Network	Worcester	CHH
	Worcester County Sheriff's Dept.	W. Boylston	J
North Worcester	Diversified VNA	Fitchburg	CHH
	Montachusett Opportunity Council	Fitchburg	CS
Hampshire/Franklin/ North Quabbin	**AIDS Care Hampshire County**	Northampton	CS, CHH
	Franklin County Sheriff's Dept.	Greenfield	J
	Hampshire County Sheriff's Dept.	Northampton	J
	Tapestry Health	Greenfield	CS
Hampden County	Baystate Medical Center	Springfield	EMM
	Center for Human Development	Springfield	CS
	Gandara Mental Health Center	Springfield	CS
	Hampden County Sheriff's Dept.	Ludlow	J
	Holyoke Health Center	Holyoke	CS, EMM
	Northern Educational Services	Springfield	CS
	River Valley Counseling Center	Springfield/Holyoke	CS, RSS, CHH
	Tapestry Health	Springfield	CS
Berkshire County	**American Red Cross of Berkshire County**	Pittsfield	CS, CHH
	Berkshire County Sheriff's Dept.	Pittsfield	J

* For a list of Client Services programs funded by the Boston Public Health Commission, visit www.bphc.org.

** Includes TIP contracts. County Sheriff's Departments are listed according to facility location, although they cover entire counties, which may include one or more service coordination areas. It is expected that representatives of these facilities will be members of all SCC bodies that include any portion of the county covered by the facility.
***By subcontract with the Boston Living Center.
[+] Subcontract with the Department of Corrections.

Bold=Case management program (funded by MDPH or BPHC)

Addendum VI
SCC Coordinator Contacts

Massachusetts Department of Public Health—HIV/AIDS Bureau

Funded Conveners for Service Coordination Collaboratives

SERVICE COORDINATION AREA(S)	FUNDED CONVENOR	CONTACT PERSON	E-MAIL	PHONE
Greater Boston/Metrowest	JRI Health	Beth Hastie Brad White	bhastie@jri.org bpwhite@jri.org	(617) 988-2605, ext. 201 (617) 988-2605, ext. 210
Northeast	Greater Lawrence Family Health Center	Gerardo Zayas Karla Gibbons	gzayas@glfhc.org kgibbons@glfhc.org	(978) 685-7663, ext. 506 (978) 685-7663, ext. 533
North Shore	Lynn Community Health Center	Susan Goldin	sgoldin@lchcnet.org	(781) 596-2502, ext. 702
South Shore, South Coast	Health Care of Southeastern MA	Marisa Howard-Karp Steve Baker	mhoward-karp@hcsm.org sbaker@hcsm.org	(508) 583-2250, ext. 229 (508) 583-2250, ext. 223
Cape & Islands	AIDS Support Group of Cape Cod	Krystin St. Onge Laura Thornton	stonge_asgcc@yahoo.com lthornton@gis.net	(508) 778-1954 (508) 487-9445
North Worcester	Montachusett Opportunity Council	John DiPaoli Nancy Madore	John_DiPaoli@yahoo.com nmadore@mocinc.org	(978) 343-4142 (978) 345-4366
Central/South Worcester	AIDS Project Worcester	Joe McKee	jmckee@aidsprojectworcester.org	(508) 755-3773
Hampden County, Hampshire/Franklin/North Quabbin	Tapestry Health	Glenn Johnson Hutson Inniss	gjohnson@tapestryhealth.org hinniss@tapestryhealth.org	(413) 747-5144 (413) 747-5144
Berkshire County	Berkshire AHEC	Lisa Fletcher-Udel Sheila Dargie	lfletcher-udel@berkshireahec.org sdargie@berkshireahec.org	(413) 447-2417 (413) 447-2417